Tribal/Indian Health Clinic (IHC)/638 Clinic Guidelines

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided by Indian Health Clinics (IHC)/638 Clinics and other Medicaid services provided by Tribes but not covered under the IHC encounter, as deemed appropriate by the Department of Health and Welfare (DHW). It addresses the following:

- Claims payment.
- Prior authorization (PA).
- Program policy.
- IHC/638 Clinic services.
- IHC/638 Clinics or Tribes as other Medicaid provider types.
- Electronic claims billing.
- Paper claims billing.

3.1.2 Payment

Medicaid reimburses IHCs for most services through an all-inclusive rate for each participant encounter.

The all-inclusive rate for IHCs is established by the Federal Office of Management and Budget as published annually in the Federal Register.

Check eligibility to see if the participant is enrolled in Healthy Connections (HC), Idaho's Medicaid primary care case management (PCCM) model of managed care. If a participant is enrolled, there are guidelines that must be followed to ensure reimbursement for providing Medicaid-covered services.

Tribal members enrolled with a primary care provider (PCP) other than the IHC do not need a referral for IHC services. However, a non-tribal member enrolled with a PCP other than the IHC will need a HC referral for IHC services.

3.1.3 Prior Authorization (PA)

Indian Health Clinic (IHC) services do not require PA for IHC services for Native Americans and Alaskan Natives. However, if the IHC is enrolled with the Idaho Medicaid Program as a provider for services other than IHC services, PA may be required.

3.2 Policy – Indian Health Clinics (IHC)/638 Clinics

3.2.1 Overview

Medicaid covers IHC/638 Clinic physician services, physician assistant services, nurse practitioner services, nurse midwife services, clinical social worker services, clinical psychologist services and specialized nurse practitioner services, and any required supplies incidental to their services through an encounter reimbursement methodology. Medicaid covers dentist services provided in IHC.

For services other than IHC/638 Clinic services or services provided by providers other than those listed above, follow the specific service definition and provider qualifications for the specific service listed in *Section 3.3.IHC/638 Clinics as Other Provider Types*.

3.2.2 Excluded Services

3.2.2.1 Laboratory

If an outside lab instead of the clinic performs a laboratory service, the outside lab must bill Medicaid directly.

Laboratory services performed in IHCs are included in the encounter rate and cannot be billed as a separate service to Medicaid. The exception to this exclusion is when an individual receives laboratory service on a day when there is no encounter billed for a clinic visit. These laboratory services may be billed but the clinic must have a separate laboratory provider number or a group physician number to bill under and use laboratory procedure codes. The reimbursement will be fee-for-service rather than an encounter rate.

3.2.2.2 Pharmacy

Over-the-counter (OTC) pharmaceuticals are not covered by Medicaid, with the exception of those OTC items identified as payable in *Section 3 Pharmacy Guidelines*. Pharmaceutical services for take home prescription medications will be covered under the Medicaid Pharmacy Program. Claims must be submitted to Medicaid on the Idaho Pharmacy claim form under the pharmacy's provider number.

Note: The clinic may not bill pharmaceutical services as an encounter.

3.2.2.2.1 *Tamper Resistant Prescription Requirements*

To comply with federal regulations, Idaho Medicaid will only pay for outpatient drugs reimbursed on a fee-for-service basis when the prescription for the covered drug is tamper-resistant. If Medicaid pays for the drug on a fee-for-service basis, and the prescription cannot be faxed, phoned or electronically sent to the pharmacy, then providers must ensure that the prescription meets all three requirements for tamper-resistant paper.

Any written prescription presented to a pharmacy for a Medicaid participant must be written on a tamper-resistant prescription form that contains all of the following:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Access to care:

The intent of this program is to reduce forged and altered prescriptions and to deter drug abuse. Emergency fills for prescriptions written on non-tamper resistant pads are permitted as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant prescription pad. The pharmacy must document the call on the face of the written prescription.

3.2.3 Encounter Definition

An encounter is a face-to-face contact for the provision of medical, mental health or dental services between a clinic patient and a physician, physician assistant, nurse practitioner, clinical social worker, clinical psychologist, specialized nurse practitioner or visiting nurse, dentist or dental hygienist. A clinic may only bill a visiting nurse visit as an encounter if the patient is homebound and the clinic is providing home health services under the provision for home health in rural areas.

- Types of encounters include medical, mental health, and dental.
    - o Each contact with a separate discipline of health professional (medical, mental health, or dental) on the same day at the same location is considered a separate encounter and may be billed as such. An Indian Health or Tribal 638 Clinic may bill a mental health encounter for services provided to a Medicaid participant with a substance abuse diagnosis when provided by a Certified Substance Abuse Counselor with an Idaho Board of Alcohol/Drug Counselor Certification (IBADCC).
    - o Substance Abuse Counselor Certifications from other states will be allowed when the certification requirements are equal to the requirements of the IBADCC.

    Note: Mental health encounters do not count toward the participants per year limit for mental health services.
- All contacts with all practitioners within a disciplinary category (medical, mental health, or dental) on the same day are considered one encounter.
- Reimbursement for services is limited to three encounters (one of each type) per participant per day. An exception to this rule may be made if the encounter is caused by an illness or injury that occurs later the same day of the first encounter, requires additional diagnosis or treatment, and is supported by documentation.
- No shows, visits to pick up medication, or incidental services on the day of the encounter are not considered an encounter.

3.2.4 Incidental Services

Services incidental to a billable encounter are:

- In-house radiology.
- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Audiology.
- In-house laboratory services.
- In-house nutritional education or dietary counseling and monitoring by a registered dietitian.

- Injectable medications.
- Medical equipment and supplies.

These services are not separately billable as an encounter. If they happen on the same day as an encounter visit they are considered included in the encounter rate.

If these services are provided by the clinic on a day when a qualifying IHC or Federally Qualified Health Center (FQHC) encounter is not provided, the clinic must have the appropriate separate provider number to bill for those services. See *Section 3.3 IHC/638 Clinics as Other Provider Types*.

Indian Health Clinics (IHC) may bill for one medical, one mental health, and one dental encounter in one day.

3.2.5 Dental Encounter

An encounter is a face-to-face contact for the provision of dental services between a participant and a dentist or dental hygienist. When billing for dental services, use the dental encounter code **D2999** with the diagnosis code **V72.2**.

Effective with dates of service on or after 9/1/07, participants who are eligible under the Medicaid Basic Plan, including pregnant women eligible for the Pregnant Women (PW) Program, are covered under a dental insurance program called Idaho Smiles. Doral Dental is the administrator for Idaho Smiles. For eligibility, benefits, and claims processing information, contact Idaho Smiles Customer Service at: **(800) 936-0978**, or by email at: **www.bcidaho.com**; click on the Idaho Smiles link, then under *Dental Providers*, pick the *provider Web portal* link which will take you to Doral's Idaho Smiles Web site.

Note: Participants' identification numbers for both Idaho Smiles and Medicaid numbers are the same. If a participant does not have an Idaho Smiles insurance card, you can still use their Medicaid identification (MID) number with the point of service POS device, PES software, or MAVIS at: **(208) 383-4310 in the Boise calling area**, or **(800) 685-3757) (toll free)** to determine eligibility. The eligibility response from EDS will indicate which dental program they are on.

- If the participant is eligible for **Medicaid Basic Plan or Pregnant Women (PW) Program**, bill Idaho Smiles.
- If the participant is eligible for Medicaid, without mention of Basic Plan or PW Program, they are on the **Medicaid Enhanced Plan**; bill EDS for dental services. For additional information about services considered a benefit of the dental program, see *Section 3 Dental Guidelines*.

3.2.6 Medical Care Evaluation for Assessment

The Medicaid Care Management Program for adults with developmental disabilities includes an assessment process which requires a history, physical examination, and referral from the physician (the participant's HC provider, if applicable).

Medicaid will reimburse history and physicals for adults when it is a Medicaid Program requirement such as above. When billing for history and physical exams for developmentally disabled adults that have been requested by the Medicaid Program, use diagnosis code **V70.3** - Other medical examination for administrative purposes. You must enter, *State required history and physical*, in the comments field of the claim or it will deny.

3.2.7 Advance Directives

An advance directive explains to a participant his or her right to accept or refuse medical services, or to choose among available medical services. The provider will inform the participant of their right to formulate advance directives, such as a Living Will and/or Durable Power of Attorney for Health Care. Medicaid has directed that providers of home health care (including FQHCs and IHCs) must provide all adult Medicaid participants with advance directive information in an understandable format.

If a participant is unable to read the information, the information is read to the participant by a relative or friend. If no one else is available, the provider must read the advance directive information to the participant. If the provider is unable to abide by the medical desires of the participant, the provider is required to assist the participant in finding an alternative source of service.

3.2.8 Procedure Codes

Idaho Medicaid uses the federally mandated HCPCS. Except for dental services, all claims must use the procedure code **T1015**, the encounter code for all medical and mental health IHC services. Bill dental services with procedure code **D2999**.

- Children's EPSDT services: see *Section 3.2.11 Child Wellness Exams,* for more information.
- Family planning services: see *Section 3.2.12 Family Planning,* for more information.

The federal Department of Health and Human Services announces new rates for Tribes for outpatient encounter (per visit) rates every year. These rates are effective January 1, of each year. IHCs should bill with the most current encounter rate. This practice will allow DHW to run mass adjustments in the event that the claims processing system does not have the most current rate of file as of January 1. However, claims that were billed with a modifier must be manually adjusted. An example of these claims would be EPSDT visits. See *Section 2 General Billing Information*, for instructions on submitting a manual adjustment for these claims.

3.2.9 Medicare Crossover

Participants may be dually eligible for Medicare and Medicaid. The provider must first bill Medicare for rendered services. A copy of the Medicare Remittance Notice (MRN) must be included with the Medicaid claim when billing on paper. If billing electronically, the information from Medicare must be entered in appropriate screens.

See *Section 2.5 Crossover Claims*, *General Billing Information,* for more information.

3.2.10 Place of Service (POS) Codes

The following POS codes are valid for IHCs. Enter the appropriate code in the POS field on the CMS-1500 claim form or in the appropriate field of the electronic claim form:

05 Indian Health Service Free-standing Facility

06 Indian Health Service Provider-based Facility

07 Tribal 638 Free-standing Facility

08 Tribal 638 Provider-based Facility

11 Office

50 FQHC

72 Rural Health Clinic

3.2.11 Child Wellness Exams

Complete information regarding child wellness exams is located in *Section 1.6 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), General Provider & Participant Information*. Sometimes child wellness exams are referred to as EPSDT screens.

Payment for child wellness exams is the same as the rate for all inclusive participant encounters. Providers report encounter code **T1015** with the appropriate modifier.

3.2.12 Family Planning

All claims for services or supplies that are provided as part of a family planning visit must include the **FP** (family planning) modifier with encounter code **T1015**.

Note: Any family planning encounters should include one of the diagnoses listed in the table below as the primary diagnosis.

Diagnosis Code	Description
V25.01	Prescription of oral contraceptive
V25.02	Initiation of other contraceptive measure (fitting of diaphragm, prescription of foams, creams, other agents)
V25.09	Family planning advice (other)
V25.1	Insertion of intrauterine contraceptive device
V25.2	Sterilization (admission)
V25.40	Contraceptive surveillance, unspecified
V25.41	Contraceptive pill surveillance
V25.42	Intrauterine device (checking, reinsertion, or removal of device) surveillance
V25.43	Implantable subdermal contraceptive surveillance
V25.49	Surveillance of other contraceptive method
V25.5	Insertion of implantable subdermal contraceptive
V25.8	Other specified contraceptive management (post-vasectomy sperm count)
V25.9	Unspecified contraceptive management

3.3 IHC/638 Clinics as Other Provider Types

3.3.1 Overview

Indian Health Clinics (IHC) provides many services that may not be billable as an IHC encounter. An IHC or Tribe may apply for and receive provider numbers to bill for these additional services. The service descriptions, provider qualifications, PA requirements (if applicable), limitations (if applicable), and where to apply can be found in this section.

3.3.2 Mental Health Clinic Services

Medicaid Basic Plan participants are eligible for up to 26 mental health visits per year.

A visit is any non-inpatient mental health service.

Mental health encounters at an IHC do not count toward the annual 26 visit limit.

3.3.2.1 Description

Mental health clinic services are designed to foster better mental health for Medicaid participants. In accordance with the *Code of Federal Regulations 42 CFR 440.90*, all mental health clinic services must be provided at the clinic, unless provided to an eligible homeless individual. A mental health clinic must be under the supervision of a physician. Clinic services are typically preventative, diagnostic, therapeutic, rehabilitative, or palliative services. Recreational, educational, and vocational services are not Medicaid covered mental health clinic services. IHCs that obtain mental health clinic provider status are governed by rules governing services provided in a Mental Health Clinic. These rules are located in *IDAPA 16.03.707-718*. Billable services include:

- Psychotherapy (evaluation; individual, group and family therapy).
- Partial care – structured therapeutic interventions that assist participants in the stabilization of behavior, functional skill acquisition. **Note:** Partial care is only covered for Medicaid Enhanced Plan participants.
- Collateral contact – contact may be billed as collateral contact when it is necessary to provide consultation or treatment direction about a Medicaid participant to a "significant other" in the participant's life, or another individual with a primary treatment relationship to the participant. The need for collateral contact should be clearly reflected in the participant's treatment plan. It must be:
  - Provided by agency staff qualified to deliver clinical services.
  - Documented in the progress notes.
- Nursing services - private duty nursing, DD, ISSH, and A&D, nursing services, and supervising registered nurse (PCS Program) are covered for Medicaid Enhanced Plan participants.
- Pharmacologic management.
- Occupational therapy evaluations and therapy.

3.3.2.2 Limitations

Evaluative or diagnostic services and individualized treatment plan development are limited to no more than 12 hours per calendar year per participant. This limitation includes all fee-for-service evaluation/diagnostic services paid to all providers and provider types.

Psychotherapy services, including group or family psychotherapy are limited to no more than 45 hours per calendar year per participant.

Note: Medicaid Basic Plan participants are limited to 26 mental health services per year. The 12 hours of evaluative or diagnostic services count towards the 26 mental health services limitation.

Partial care services are payable up to a maximum of 36 hours per week per eligible participant.

Note: Partial care services are only covered for Medicaid Enhanced Plan participants.

3.3.2.3 Provider Qualifications

Licensed, qualified professionals providing mental health clinic services to eligible Medicaid participants must have, at a minimum, one or more of the following qualifications:

- Licensed Psychiatrist.
- Licensed Physician.
- Licensed Psychologist.
- Psychologist Extender, registered with the Board of Occupational Licenses.
- Licensed Masters Social Worker, Licensed Clinical Social Worker, or Licensed Social Worker.
- Licensed Clinical Professional Counselor or Licensed Professional Counselor.
- Licensed Marriage and Family Therapist.
- Certified Psychiatric Nurse, R.N., as described in *IDAPA 16.03.09.456.02.*
- Licensed Register Nurse, R.N.
- Registered Occupational Therapist, O.T.R.

To enroll as a Mental Health Clinic, contact EDS Provider Enrollment at:

(208) 383-4310 in the Boise calling area

(800) 685-3757 (toll free)

3.3.2.4 Procedure Codes

Indian Health Clinics that choose to enroll as a Mental Health Clinic must follow the guidelines published in *Section 3 Clinic Guidelines.*

3.3.3 Rehabilitative Services

3.3.3.1 Description

Indian Health Clinics (IHC) that wish to provide community-based mental health services must do so under a Psychosocial Rehabilitation Provider agreement. Psychosocial rehabilitative services are not limited to a clinic setting as are IHC and mental health clinic services. The rules governing the provision of these services are located in *IDAPA 16.03.10.110-146*. Also see *Section 3 Rehabilitative Options.*

Rehabilitative mental health services (also called Rehabilitative Option or PSR services) include treatment, rehabilitation, and supportive services. The goal of rehabilitative services is to reduce to a minimum an individual's mental disability and restore the participant to the highest functional level within the community.

Note: Mental health rehabilitation services are covered for Medicaid Enhanced Plan participants.

Billable services include:

- Comprehensive assessment (See *IDAPA 16.03.10.113*)
- Written service plan (See *IDAPA 16.03.10.114*)
- Pharmacological management (See *IDAPA 16.03.10.123.01*)
- Individual psychosocial rehabilitation (See *IDAPA 16.03.10.123.02*)
- Group psychosocial rehabilitation (See *IDAPA 16.03.10.123.03*)
- Crisis intervention service (See *IDAPA 16.03.10.123.04*)

- Collateral contact (See *IDAPA 16.03.10.123.05*)
- Nursing services (See *IDAPA 16.03.10.123.06*)
- Psychotherapy (See *IDAPA 16.03.10.123.07*)
- Family psychotherapy (See *IDAPA 16.03.10.123.08*)
- Occupational therapy (See *IDAPA 16.03.10.123.09*)

http://adm.idaho.gov/adminrules/rules/idapa16/0310.pdf

3.3.3.2 Provider Qualifications

Licensed, qualified professionals providing PSR services to eligible Medicaid participants must have, at a minimum, one or more of the following qualifications:

- Licensed Physician or Psychiatrist.
- Licensed Master's Level Psychiatric Nurse.
- Licensed Psychologist.
- Licensed Clinical Professional Counselor or Licensed Professional Counselor.
- Licensed Marriage and Family Therapist.
- Licensed Masters Social Worker or Licensed Clinical Social Worker.
- Clinician.
- Licensed Pastoral Counselor.
- Licensed Social Worker.
- Licensed Professional Nurse (R.N.).
- Psychosocial Rehabilitation (PSR) Specialist.
- Registered Occupational Therapist, O.T.R.
- Psychologist Extender.

To enroll as a Psychosocial Rehabilitation Provider contact the Regional Mental Health Program.
http://adm.idaho.gov/adminrules/rules/idapa16/0310.pdf

3.3.3.3 Eligibility

Children with a serious emotional disturbance (SED) are eligible for rehabilitative mental health services. See *IDAPA 16.03.10.112.01, 02, 04* and *05* for qualifying criteria. Also, participants who are 18 years of age or older with a diagnosis of severe and persistent mental illness that directly impacts at least two identified functional areas are eligible for these services. Rules governing the provision of these services are located in *IDAPA 16.03.10.112.03*.

Medicaid Basic Plan participants are eligible for up to 26 mental health visits per year. A visit is any non-inpatient mental health service. Mental health encounters do not count toward the annual 26 visit limit.

3.3.3.4 Limitations

- Assessment and service plan development – limited to 6 hours annually.
- Psychotherapy – limited to 24 hours annually.
- Crisis intervention service – limited to 20 hours per crisis during any consecutive five day period. Must be prior authorized or authorized retrospectively.
- Psychosocial rehabilitation – limited to 20 hours per week.

Note: PSR services are covered for Medicaid Enhanced Plan participants.

3.3.3.5 Procedure Codes

Indian Health Clinics (IHC) that choose to enroll as a psychosocial rehabilitation provider should refer to *Section 3 Rehab Options Guidelines*, for procedure codes and specific billing instructions.

3.3.3.6 Prior Authorization (PA)

Psychosocial rehabilitation services require PA from DHW.

3.3.4 Case Management Services (Service Coordination)

Case management services are covered for Medicaid Enhanced Plan participants.

3.3.4.1 Description

Indian Health Clinics (IHC) who want to bill for service coordination services must do so under a Service Coordination provider agreement. See *IDAPA 16.03.10.720 Service Coordination*. Service coordination is defined as a brokerage model of case management.

Reimbursable services include:

- Assessment and service plan development.
- Linking the individual to services.
- Monitoring and coordinating services.

Note: Service coordination is covered for Medicaid Enhanced Plan participants.

3.3.4.2 Provider Qualifications

All service coordinators must have a minimum of the following:

- BA or BS degree in a human services field from a nationally accredited university or college; or
- Licensed professional nurse (R.N.); and
- A minimum of one year experience working with the population they will be serving or be supervised by a qualified service coordinator; and
- Pass DHWs criminal history check.
- Agencies may use paraprofessionals to assist in the implementation of a service coordination plan (except for plans for participants with mental illness). Paraprofessionals must:
  - Be able to read and write at a level equal with the paperwork and forms involved in the provision of the service; and
  - Pass DHWs criminal history check.

To enroll as a service coordination provider:

- For PCS/HCBS and DD populations, contact your Regional Medicaid Services (RMS).
- For EPSDT service coordination, contact your Regional Children's ACCESS Unit.
- For mental health service coordination, contact EDS Provider Enrollment.

3.3.4.3 Eligibility

Medicaid reimburses for service coordination services for four target populations:

- Participants 18 years of age or older diagnosed with a developmental disability who have substantial functional limitations in three or more major life areas and need assistance to adequately access services and supports necessary to maintain their independence in the community. (*IDAPA 16.03.10.723*)

- Participants (adults and children) who have been approved to receive state plan PCS or HCBS and require assistance to access services and supports to maintain their independence in the community. (*IDAPA 16.03.10.724*)
- Participants 18 years of age or older who are using or have a history of using high cost medical services associated with periods of increased severity of mental illness; and are diagnosed with a condition of severe and persistent mental illness that is listed in the DSM-IV-TR) (See *IDAPA 16.03.10.725* for classification codes); and have illness of sufficient severity to cause a disturbance in their role performance or coping skills in at least two life areas on a continuous or intermittent basis. (*IDAPA 16.03.10.725*)
- Participants from birth through the month of their twenty first birthday identified in an EPSDT screen as having a **developmental delay or disability, special health care needs, or severe emotional disorder** and need assistance in one or more of the problems listed in *IDAPA 16.03.17.204.03* associated with their diagnosis. (*IDAPA 16.03.17.204*)

3.3.4.4 Limitations

Service coordination is not covered for participants who are eligible under the Medicaid Basic Plan, who receive hospice services, or who live in a hospital, nursing facility, or ICF/MR. Service coordination services are limited to:

- Five hours per month for participants with mental illness.
- Eight hours per month for participants receiving personal care or waiver services.
- Flat monthly fee for individuals with developmental disabilities and children.
- Six hours for the initial assessment and plan development (one time reimbursement).
- See IDAPA 16.03.17 for additional reimbursement for crisis service coordination.
- Participants are only eligible for one type of service coordination at a time.
- Service coordination is not reimbursable when the individual is incarcerated.

3.3.4.5 Procedure Codes

Indian Health Clinics (IHC) that choose to enroll as service coordination providers should refer to *Section 3 Service Coordination Guidelines*, for procedure codes and specific billing instructions.

3.3.4.6 Prior Authorization (PA)

All service coordination services (except for participants with severe and persistent mental illness) must be prior authorized by DHW.

3.3.5 Personal Care Services (PCS)

3.3.5.1 Description

The number of American Indian and Alaska Native (AIAN) elders is growing rapidly. This places new pressures on Indian Health Services (IHS) to provide long-term care for AIAN elders. Institutional care is not desired by most elders and has high costs for both the elders and the tribal governments. In contrast, less expensive home care can provide enough assistance to keep most disabled elders in their own or their relatives' homes, where they prefer to be. Medicaid covers in-home services, both through state plan PCS or, for participants with more complex needs, through the Aged and Disabled Home and Community Based Services waiver.

Indian Health Services should apply to be a provider of these services for the following reasons:

- To help AIAN elders and disabled participants who need assistance with daily activities like bathing, dressing, etc.
- To create new sources of employment for tribal members while offering culturally competent care.
- To generate new revenue for tribal health programs.

Personal care services (PCS) are medically oriented tasks related to a participant's physical care in the home. (See *IDAPA 16.03.10.300* for rules governing this service.) Such services must be included in an approved plan of care (POC) and include, but are not limited to, the following:

- Assistance with personal hygiene.
- Assistance with medications that are ordinarily self-administered.
- Meal preparation.
- Incidental household services essential to the participant's comfort, safety and health.
- Independence training.

Note: PCS are covered for Medicaid Enhanced Plan participants.

3.3.5.2 Provider Qualifications

All personal assistants must have at least one of the following qualifications:

- Licensed Registered Nurse (RN)
- Licensed Practical Nurse (LPN)
- A person who meets the standards of section 39-5603 of Idaho Code and receives training to ensure the quality of services. Must be at least 18 years of age. The RMS may require a Certified Nursing Assistant (CNA) if, in their professional judgment, the participant's medical condition warrants a CNA.

To enroll a PCS provider, contact the RMS office in your area.

3.3.5.3 Eligibility

Adults and children are eligible for PCS service if the service is determined to be medically necessary and provided in accordance with a written POC.

3.3.5.4 Limitations

PCS under the State Plan Option are limited to:

- 16 hours per week per participant.
- Participants who meet medical necessity criteria under EPSDT (IDAPA 16.03.09.535 may receive up to 24 hours per day of service. delivery through the month of their 21st birthday.
- Must be provided in the participant's home or personal residence.

3.3.5.5 Procedure Codes

Indian Health Clinics (IHC) that choose to enroll as a PCS provider should refer to *Section 3 Personal Care Services Guidelines*, for procedure codes and specific billing instructions.

3.3.5.6 Prior Authorization (PA)

Regional Medicaid services (RMS) must authorize all services reimbursed by Medicaid under the PCS program prior to the payment of services. Approved authorizations are valid for the dates shown on the PA. The PA number must be included on the claim.

3.3.6 Aged and Disabled Waiver Services (A&D)

3.3.6.1 Description

Idaho's elderly and disabled citizens can often maintain self-sufficiency, individuality, independence, dignity, choice and privacy in a cost-effective home-like setting instead of an institution. These services may be provided in the person's own home or apartment; the home of relatives who are primary non-paid care providers; adult foster homes; residential care facilities; assisted living facilities; and the community.

They include:

- Adult day care.
- Adult residential care.
- Non-medical transportation.
- Specialized medical equipment and supplies.
- Attendant care.
- Psychiatric consultation.
- Service coordination.
- Chore services.
- Companion services.
- Consultation services.
- Homemaker services.
- Home-delivered meals.
- Environmental accessibility adaptations.
- Respite care services.
- Nursing services.
- Personal Emergency Response System (PERS) services.
- Supported employment.
- Behavior Consultation/Crisis Management (BC/CM).
- Residential habilitation (RES/HAB).
- Day habilitation.

  Note: A&D waivered services are covered for Medicaid Enhanced Plan participants.

3.3.6.2 Provider Qualifications

All providers of homemaker, respite care, adult day care, transportation, chore, companion, attendant adult residential care, home delivered meals, and behavior consultation must meet, either by formal training or demonstrated capacity, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks/activities in DHWs approved A&D Waiver as approved by the Centers for Medicare and Medicaid Services (CMS).

A waiver provider cannot be the spouse or parent of a minor child to whom they are providing services.

To enroll as an A&D Waiver provider, contact your RMS

- **Adult Day Care:** Must meet all applicable state laws and regulations and have adequate staff to meet the needs of the participants accepted for admission.

- **Adult Residential Care**: Must meet all applicable state laws and regulations and have adequate staff to meet the needs of the participants accepted for admission.
- **Non-medical transportation**: Must be enrolled as a waiver provider and have a valid driver's license and liability insurance for the vehicle operated.
- **Specialized medical equipment and supplies:** Must be enrolled in the Medicaid program as a participating medical vendor provider.
- **Attendant Care:** Must be an employee of an agency or fiscal intermediary and selected, trained and supervised by the participant or the participant's family.
- **Psychiatric Consultation:** Must have Master's degree in a behavioral science; and be licensed in accordance with state law/regulations; or have a BA and work for an agency with direct supervision from a licensed Ph.D. psychologist and have one year experience in treating severe behavior problems.
- **Service Coordinator:** Must meet the same requirements as a PCS Service Coordinator (See *IDAPA 16.03.17*).
- **Chore Services:** Must be employed by an agency or fiscal intermediary. If employed by a fiscal intermediary, the employee is selected, trained and supervised by the participant or participant's family. The provider must be skilled in the type of service to be provided and demonstrate the ability to provide services according to a POC.
- **Companion Services:** Must be employed by an agency or fiscal intermediary. If employed by a fiscal intermediary, the employee is selected, trained, and supervised by the participant or participant's family.
- **Consultation Services:** Must be provided through a PCS agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training and supervising their own providers.
- **Homemaker Services:** Must be employed by an agency or fiscal intermediary. If employed by a fiscal intermediary, the employee is selected, trained and supervised by the participant or participant's family. Must be capable of providing the duties on the Service Plan.
- **Home-Delivered Meals:** Must be a public agency or private business capable of : 1) supervising the direct service; 2) providing assurances that each meal meets one-third of the Recommended Daily Allowance as defined by the Food and Nutrition Board of National Research Council; 3) delivering meals in accordance with the POC in a sanitary manner at the correct temperature for the specific type of food; 4)maintain documentation that the meals served are made from the highest USDA grade for each specific food type; and 5) must be inspected and licensed as a food establishment by the District Health Department.
- **Environmental Accessibility Adaptations:** Must be provided by an individual or business properly licensed or certified to provide the necessary home modifications.
- **Respite Care Services:** Meet the qualifications for the type of services to be rendered, have received instructions in the needs of the participant who will be provided the service; demonstrate the ability to provide services according to a POC; have good communication and interpersonal skills; be willing to accept supervision by a provider agency or the primary caregiver; and be free of communicable diseases.
- **Nursing Services:** Must be licensed as an RN or LPN in Idaho or practicing on a federal reservation and licensed in another state.
- **Personal Emergency Response System (PERS) Services:** Must have a Land Mobile License from the FCC.

- **Supported Employment:** Supplied by an agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF); or Rehabilitation Services Accreditation System (RSAS)
- **Residential Habilitation (RES/HAB):** Must meet the requirements of *IDAPA 16.03.10.329,* and provide service according to an ISP, have completed training in rights of persons with disabilities, and any training required by the specific needs of the participant.
- **Behavior Consultation/Crisis Management (BC/CM):** Supplied by psychiatrist, pharmacist, psychologist, licensed as an RN or LPN in Idaho or practicing on a federal reservation and licensed in another state, or qualified mental retardation professional (QMRP).
- **Day Rehabilitation:** Must meet the requirements of *IDAPA 16.03.10.329 Aged Or Disabled Waiver Services – Provider Qualifications And Duties,* and provide services according to an ISP.

3.3.6.3 Eligibility

To be eligible for Medicaid payment of waiver services, RMS must determine that the all of the following criteria are met:

- The participant requires services due to a physical or cognitive disability, which results in a significant impairment in functional independence as demonstrated by findings of a Uniform Assessment Instrument (UAI).
- The participant is capable of being maintained safely and effectively in a non-institutional setting.
- The participant would need to reside in a nursing facility in the absence of waiver services. Medicaid expenditures for the care of the participant in the community will be no more than the Medicaid Program costs would be for that participant's care in a nursing facility.
- The participant is enrolled in the Medicaid Enhanced Plan.

3.3.6.4 Procedure Codes

Indian Health Clinics (IHC) that choose to enroll as an A&D Waiver provider should refer to the *Section 3 Aged and Disabled Guidelines*, for procedure codes and specific billing instructions.

3.3.6.5 Prior Authorization (PA)

RMS in the Region must authorize all services reimbursed by Medicaid under the A&D Waiver Program before services are rendered. The PA number must be included on the claim or the claim will be denied.

3.3.7 Physician Provider Group

3.3.7.1 Description

There are times when a tribe cannot bill for services under the encounter. By having a Physician Group provider number, the tribe would have an avenue to bill for these services. Examples are:

- Pathology/Laboratory services provided when there has not been a qualifying office visit on the same day.
- Visits by the physician when a participant is in a hospital or nursing facility.
- Radiology services provided when there has not been a qualifying office visit on the same day.
- Diabetes education and training.

3.3.7.2 Provider Qualifications

All physicians, licensed to practice medicine in any U.S. state, are eligible to participate in the Idaho Medicaid Program. They must obtain an Idaho Medicaid provider number from the Idaho Medicaid Program.

To enroll as a physician, or mid-level provider, contact EDS Provider Enrollment at:

(208) 383-4310 in the Boise calling area

(800) 685-3757 (toll free)

Services provided by employees of a physician may not be billed directly to the Idaho Medicaid Program. There are two exceptions:

- Psychological testing services provided by a licensed psychologist or social worker.
- Diabetes education and training (counseling) provided by a Certified Diabetes Educator.

Psychological testing services

Physician groups may bill for psychological testing services provided by a licensed psychologist or social worker. They are billed under the physician provider number. **This exception applies to testing only.**

Diabetes Counseling Education

Physician groups may bill for diabetes education and training (counseling) provided by a Certified Diabetes Educator (CDE) through an American Diabetes Association (ADA) Recognized Diabetes Education Program.

Diabetes education and training services are limited to 24 hours of group sessions and 12 hours of individual counseling every five calendar years.

A one-time provider review is required in order to provide diabetes counseling and education training. The following information must be sent to:

Office of Medicaid Automated Systems (MAS)
PO Box 83720
Boise, ID 83720-0036
Fax: (208) 364-1911

- Current Idaho Medicaid provider number (for Tribes, this must be a physician clinic number, not their IHC number).
- Whether you will be providing individual or group counseling or education.
- A current copy of the diabetic counselor's certificate.

Mid-level practitioners

Indian Health Clinics (IHC) that provide clinic services though a nurse practitioner, physician assistant, or a nurse midwife must obtain a mid-level provider number for non-encounter services provided by these practitioners.

3.3.7.3 Procedure Codes

Indian Health Clinics (IHC) that choose to enroll as a physician provider should refer to *Section 3 Physician Guidelines*, for procedure codes and specific billing instructions.

3.3.8 Audiology Services

3.3.8.1 Overview

If audiology services are provided on the same day as an encounter, the service is considered part of the encounter. If rendered by a provider other than listed as those who can provide IHC services, an audiology provider number must be obtained.

3.3.9 Vision Services

Services provided by an ophthalmologist are billable as an encounter under the IHC/638 Clinic number. However, vision exams provided by other qualified providers such as optometrists must be billed under a vision service provider agreement.

3.3.10 Physical Therapy

3.3.10.1 Overview

Medicaid covers physician-ordered physical therapy rendered by a licensed physical therapist in the participant's home or in the therapist's office.

- Must be part of a POC.
- Progress must be reviewed and plan updated every 30 days unless the therapist has documentation from the physician indicating that a chronic condition exists that will require therapy for more than six months. In these cases, a physician order for continued care is required every six months.
- The POC must stipulate the type of physical therapy needed, frequency of treatment, expected duration, anticipated outcomes, and MD signature and date. A copy of the order must be maintained in the participant's file.

To enroll as a physical therapy provider, contact EDS Provider Enrollment at:

(208) 383-4310 in the Boise calling area
(800) 685-3757 (toll free)

3.3.10.2 Limitations

Physical therapy visits are limited to 25 visits per participant during any calendar year (January through December) regardless of the billing provider. Visits exceeding the 25 visit limitation must be prior authorized before services are rendered. See *Section 3 Health Care Providers of the Healing Arts*, for specific PA information.

3.3.10.3 Documentation

The POC is not required as an attachment to the claim, but must be maintained by the provider.

3.3.10.4 Excluded Services

The following services are excluded from payment as physical therapy:

- Group exercise therapy.
- Group hydrotherapy.
- Acupuncture.
- Biofeedback.

3.3.11 Pathology/Laboratory

Pathology/laboratory services provided on a day when the participant does not see a health care provider in the clinic may not be billed as an encounter. The provider may bill for the laboratory services in these instances under a physician group provider number as previously mentioned or may apply for a laboratory provider number through EDS.

To enroll as a pathology/laboratory provider, contact EDS Provider Enrollment at: **(208) 383-4310** or **(800) 685-3757**.

3.3.12 Radiology

Radiology services provided on a day when the participant does not see a health care provider in the clinic may not be billed as an encounter. The provider may bill for the radiology services by applying for a radiology provider number through EDS.

To enroll as a pathology/laboratory provider, contact EDS Provider Enrollment at:

(208) 383-4310 in the Boise calling area
(800) 685-3757 (toll free)

3.3.12.1 Covered Services

The technical component includes charges for the following:

- Personnel.
- Material, including usual contrast media and drugs.
- Film or xerograph.
- Space, equipment, and other facility charges.

The technical component does not include radioisotopes or non-iodine contrast media. List the separate charges for radioisotopes. To be assured of adequate reimbursement, attach an invoice identifying the cost of the radioisotope, the manufacturer, and the strength and dosage administered, or attach medical records with the related information. Because of the wide variations in costs, to providers and the radioisotopes billed, this information is necessary to price each claim.

3.3.12.2 Modifiers

To identify a charge for the technical component, use the appropriate 5-digit CPT procedure code with the TC modifier.

For more details on billing codes, see *Section 3 Health Care Providers of the Healing Arts Guidelines*.

3.3.13 Home Health

Indian Health Clinics are allowed to bill for home health visits for participants that are homebound. However, the homebound is not a requirement for home health. Clinics who wish to provide home heath services for non-homebound Medicaid participants must apply for a Home Health Provider agreement through EDS. See *Section 3 Home Health Guidelines*, for more information.

Note: Home health services are covered for Medicaid Enhanced Plan participants.

3.3.14 Hospice

Hospice services may only be provided through a hospice provider agreement. See *Section 3 Hospice Guidelines*, for details.

Note: Hospice services are covered for Medicaid Enhanced Plan participants.

3.3.15 Dietitian Services

Medicaid allows reimbursement for Dietitian services in very limited circumstances. See *Section 3 Health Care Providers of the Healing Arts Guidelines*, for more information.

3.3.15.1 PW Nutritional Services

Nutritional services for women on the PW program may be billed when all of the following criteria are met:

- Must be ordered by a physician, nurse practitioner, or nurse midwife.
- Must be delivered after confirmation of pregnancy.
- Extends only through the 60th day after delivery.
- Limited to two visits during the covered period.

3.3.15.2 EPSDT Nutritional Services

Nutritional services for participants through the month of their 21st birthday when all of the following criteria are met:

- Must be identified through an EPSDT screen.
- Must be ordered by a physician.

- Must be determined to be medically necessary.
- Cannot be due to obesity.
- Must be billed with diagnosis code **V20.1** or **V20.2**
- Limited to two visits per calendar year without PA; up to two additional visits may be allowed with PA by the EPSDT Coordinator.

3.3.16 Podiatry

Podiatry services are covered for acute foot conditions. Acute foot conditions are defined as any condition that hinders normal function, threatens the individual, or complicates any disease. However, preventative foot care may be provided in the presence of vascular restrictions or other systemic diseases.

3.3.16.1 Service Limitations

The following podiatry services are covered only under specific conditions:

- Care of the foot and ankle – limited to the area from the mid-calf down.
- Orthotics – only if prior authorized.
- Muscle testing and range of motion studies – only if billed separately from outpatient visits for evaluation and management. Medicaid considers these services part of a routine office visit.
- Surgical removal of corns and calluses – only when there is systemic disease present.
- Cutting, removal, debridement or other surgical treatment of toenails – only when there is an acute condition or systemic disease present.

3.3.16.2 Non-Covered Services

The following podiatry services are generally not covered:

- Daily care in an inpatient hospital setting (reviewed on a case by case basis).
- Daily inpatient care in a long term care facility (NF or ICF/MR).

3.3.16.3 Diagnosis Codes

All claims must list the appropriate ICD-9-CM diagnosis code for acute conditions. The acute condition must be indicated on the initial claim and all subsequent claims.

3.4 Claim Billing

3.4.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

Note: All claims must be received within 12 months (365 days) of the date of service.

3.4.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2.2.1 Electronic Claims Submission, General Billing Information,* for more information.

3.4.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

Referral number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a HC participant. For HC participants, enter the provider's 9-digit HC referral number.

Prior authorization (PA) numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the transaction.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

Diagnosis codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

National Drug Code (NDC) information with HCPCS and CPT codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.18.6.3 Physician Guidelines,* for more information.

Electronic crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.4.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07042006

3.4.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form
- Print legibly using black ink or use a typewriter
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field
- Keep claim form clean; use correction tape to cover errors
- Enter all dates using the month, day, century, and year (MMDDCCYY) format; note that in field **24A** (From and To Dates of Service) there are smaller spaces for entering the century and year; Refer to specific instructions for field **24A**
- You can bill with a date span (From and To Dates of Service) **only if** the service was provided every consecutive day within the span
- A maximum of six line items per claim can be accepted; if the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements; total each claim separately
- Be sure to sign the form in the correct field; claims will be returned that are not signed unless EDS has a signature on file
- Do not use staples or paperclips for attachments; stack the attachments behind the claim
- Do not fold the claim form(s); mail flat in a large envelope (recommend 9 x 12)
- Only one PA number is allowed for paper claims
- When billing medications with HCPCS/CPT codes, an NDC Detail Attachment must be filled out and sent with the claim

3.4.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.4.3.3 Completing Specific Fields of CMS-1500

Consult the, Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

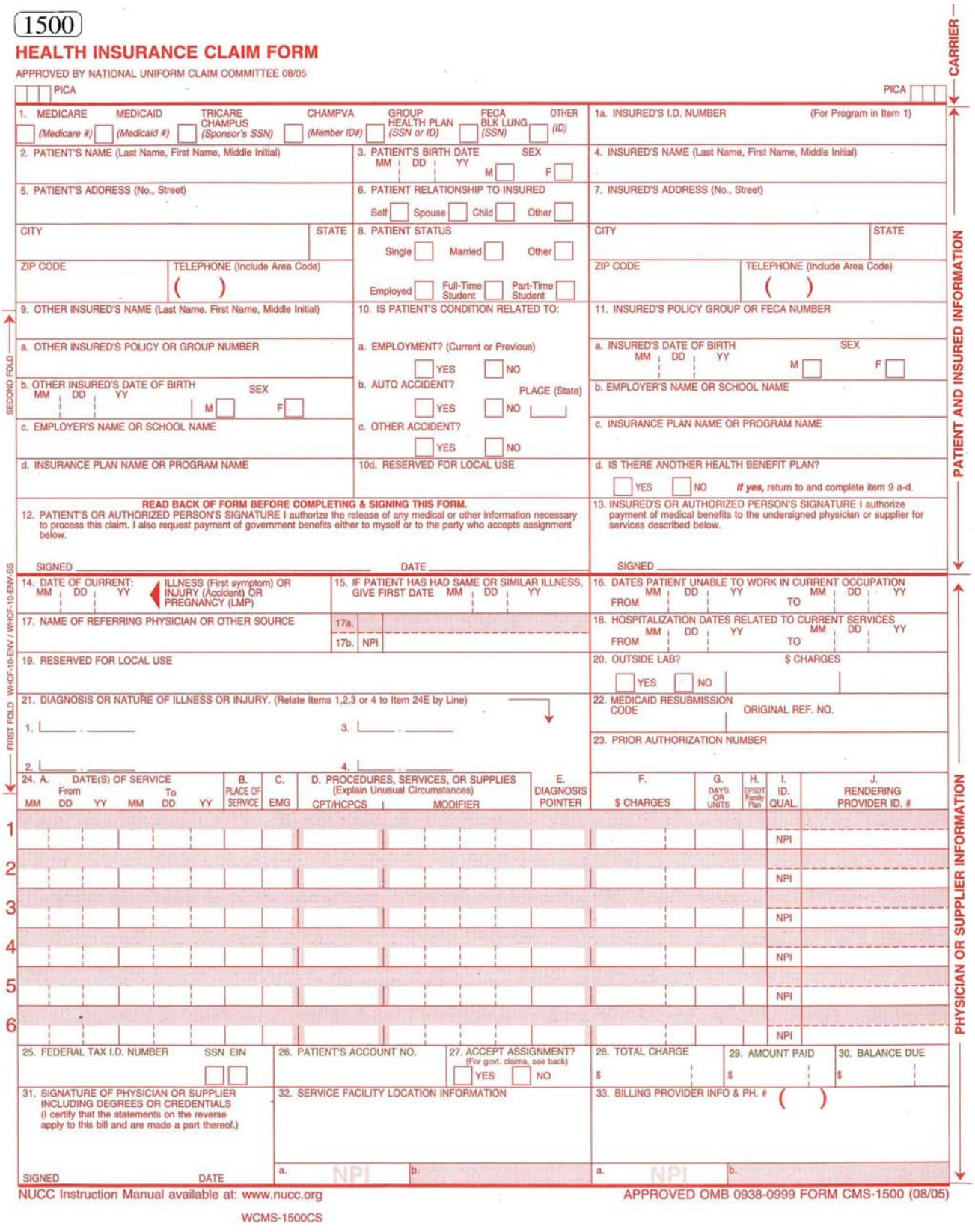
Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the MAID card.
2	Patient's Name	Required	Enter the participant's name exactly as it appears on the MAID card. Be sure to enter the last name first, followed by the first name and middle initial.

Field	Field Name	Use	Directions
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field **11d** is marked yes.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items **9a-9d**.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections participant. Enter the referring physician's name.
17a	Other ID	Required if applicable	Use this field when billing for consultations or Healthy Connections participants. For consultations enter the qualifier **1D** followed by the referring physician's 9-digit Idaho Medicaid provider number. For Healthy Connections participants, enter the qualifier **1D** followed by the 9-digit Healthy Connections referral number. **Note**: The HC referral number is not required on Medicare crossover claims.
17b	NPI Number	Not Required	Enter the referring provider's 10-digit NPI number. **Note:** The NPI number, sent on paper claims, will not be used for claims processing.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to four) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.

Field	Field Name	Use	Directions
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24C	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an **X**.
24D 1	Procedure Code Number	Required	Enter the appropriate five character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field **21**.
24F	Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, see *Section 1.6 EPSDT*, for more information.
24I	ID. Qualifier	Required if Legacy ID	Enter qualifier **1D** followed by the 9-digit Idaho Medicaid provider number in **24J**.
24J	Rendering Provider ID Number	Required if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the **1D** qualifier was entered in **24I**. **Note:** If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID Number field. **Note:** Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	The total charge entered should be equal to all of the charges for each detail line.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Balance due should be the difference between the total charges minus any amount entered in the amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See *Section 1.1.4 Signature-on- File Form,* for more information.
33	Provider Name and Address	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or RA. **Note:** If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33A	NPI Number	Desired but not required	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.

Field	Field Name	Use	Directions
33B	Other ID	Required	Enter the qualifier **1D** followed by the provider's 9-digit Idaho Medicaid provider number. **Note:** All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.4.3.4 Sample Paper Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. #

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS